DEMOGRAPHICS AND PATIENT INFORMATION

Date of Admit/Date of First Contact (NAACCR Item #580)

Description
The date of first admission/contact with the reporting facility for diagnosis and/or treatment of this cancer. If previously diagnosed/treated elsewhere, the date of first admission to your facility with diagnoses of active cancer.

Explanation
This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

Coding Instructions
1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

2. Enter the date of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

3. Date format is:
a. YYYYMMDD

Example: The patient is first seen at this facility on January 4, 2012 with a diagnosis of cancer. Record the date of admit: 20120104

4. A date **must** be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test, or emergency room visit at your facility with active cancer.

5. For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.

6. For “read only” or “pathology only” cases, enter the date the specimen was collected. These are cases where a specimen is sent to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is **NOT** a free standing entity. The class of case should be coded to 43 and the reporting source would be 3.

Note: FORDS instructions (see FORDS pg 91) differ from TCR instructions. FORDS requires that for analytic cases *Date of First Contact* is the date the patient qualifies as an analytic case *Class of Case* 00-22. If the patient was admitted for non-cancer-related reasons, the *Date of First Contact* is the date the cancer was first suspected during the hospitalization. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood

that ACoS facilities will continue to follow the rules according to FORDS.

Examples:
a. A patient is admitted to the hospital on January 31, 2012, with chest pains. On February 2, 2012, a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 20120131.

b. A patient has a biopsy in a staff physician's office on March 17, 2012, and the specimen is sent to the reporting facility's pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 21, 2012, for a wide re-excision. Record the date of first contact as 20120317.

c. A patient has a lymph node biopsy at a small hospital on May 15, 2012. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b-cell lymphoma. The patient never enters your hospital. Record 20120515 as the date of first contact.

Registry/Accession Number (NAACCR Item #550) (FORDS pg. 33)

Description
A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

Explanation
This data item serves as a reference number to protect the identity of the patient.

Coding Instructions
1. The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.

Example:
2012000001 would indicate the first 2012 case reported from a facility.

2. Do not assign a new registry number to a patient previously reported to the TCR with a new primary cancer. Within a registry, all primaries for an individual must have the same accession number.

Reporting Facility Number (NAACCR Item #540)

Description
Identifies the facility or institution reporting the case.

Explanation
This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

1. Enter the three-digit facility number assigned by the TCR.

2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin. See page 11 for contact information.

Type of Reporting Source (NAACCR Item #500) (SEER pgs. 18-20)

Description

This data item identifies the source documents used to abstract the case being reported. This will not necessarily be the document that identified the case but the document that provided the best information.

Explanation

This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only, or diagnosed by death certificate only.

Coding Instructions

1. Enter the code for the source of the facility and/or documents used to abstract the case.

Code	Label	Source Documents	Priority
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records	-Hospital inpatient -Offices/facilities with unit record HMO physician office or group HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic Includes outpatient services of HMOs and large multi-specialty physician group practices with unified records	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	-Facilities with a stand-alone medical record Radiation treatment centers Medical oncology centers (hospital-affiliated or independent) There were no source documents from code 1.	2
3	Laboratory Only (hospital-affiliated or independent)	-Laboratory with stand-alone medical record There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	-Physician's office that is NOT an HMO or large multi-specialty physician group practice. There were no source documents from codes 1, 2 or 8.	4
5	Nursing/Convalescent Home/Hospice	-Nursing or convalescent home or a hospice. There were no source documents from	6

Code	Label	Source Documents	Priority
		codes 1, 2, 8, 4, or 3.	
6	Autopsy Only	-Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	-Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6.	8
8	Other hospital outpatient units/surgery centers	-Other hospital outpatient units/surgery centers. Includes but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

Note: Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6, 7 if more than one source is used.

Definitions:

Comprehensive, unified medical record: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

Stand-alone medical record: An independent facility; a facility that is not part of a hospital or managed care system. An independent medical record containing only information from encounters with that specific facility.

Managed health plan: Any facility where all of the diagnostic and treatment information is maintained in one unit record. The abstractor is able to use the unit record when abstracting the case.

Examples: HMOs or other health plans such as Kaiser, Veterans Administration, or military facilities.

Physician office: Examinations, tests and limited surgical procedures may be performed in a physician's office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient usually does not stay overnight.

Unit record: The office or facility stores information for all of a patient's encounters in one record.

Examples:
a. A patient is admitted to your facility and expires before any treatment is rendered. An autopsy is performed and cancer is found in the lung. Code the reporting source to 6 (autopsy only). The autopsy report is the only document used for your cancer information. The patient was not known to have cancer prior to the autopsy.

b. A patient is admitted to your hospital and is diagnosed with lung cancer. Code the reporting source to 1 (Facility Inpatient/ Outpatient or Clinic). All documents in the medical record are used to gather the cancer information.

Medical Record Number (NAACCR Item #2300) (FORDS pg. 36)

Description
The number assigned to a patient's medical record by the reporting facility.

Explanation
This number identifies the individual patients within a reporting facility. It allows a reporting facility to easily locate a patient's health information. This health information is referenced when abstracting or updating a cancer case or to help identify multiple reports and primaries on the same patient.

Coding Instructions
1. Enter the eleven digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.

2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP followed by nine 0's in this field. See the list below for other optional medical record identifiers.

3. Optional medical record identifiers:

Code	Definition
ER	Emergency Room patient without a medical record number
OP	Outpatient without a medical record number
RT	Radiation Therapy department patient without a medical record number
SU	One-day surgery unit patient without a medical record number
UNK	Medical record number unknown

Class of Case (NAACCR Item #610) (FORDS pgs. 86-88)

Description
Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

Explanation
This data item divides case records into analytic and non-analytic categories. The class of case determines which cases should be included in the analysis of the facility's cancer experience.

Note: All reporting facilities must report their non-analytic cases to the TCR, regardless of their approval status with the ACoS.

A. **Analytical cases (codes 00-22):** Diagnosed at the reporting facility and/or received any of the first course treatment at the reporting facility. Abstracting for class of case 00 through 14 is to be completed within six months of diagnosis. This allows for treatment information to be documented in the patient's medical record. Abstracting for class of case 20 through 22 is to be completed within six months of first contact with the reporting facility. These cases are analyzed because the facility was involved in the diagnostic and therapeutic decision-making.

Note: A facility network clinic or outpatient center belonging to the facility is part of the facility.

B. **Non-analytical cases (codes 30-49 and 99):** Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility. Non-analytical cases (classes 30-49 and 99) are usually excluded from a facility's routine treatment or survival statistics.

Note: Per TCR reporting guidelines, non-analytical cases are reportable by all facilities for cases diagnosed January 1, 1995 and forward when there is documentation of active cancer or if the patient is receiving cancer directed therapy.

Note: Non-analytical cases, classes 49 and 99, are to be used solely by the central registry.

Coding Instructions

1. Code the *Class of Case* that most precisely describes the patient's relationship to the facility.

2. Code 00 applies only when it is known the patient went elsewhere for treatment. If that information is not available, code *Class of Case* 10.

3. Code 34 or 36 if the diagnosis is benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 or for any site other than meninges (C70_), brain (C71_), spinal cord, cranial nerves, and other parts of central nervous system (C72_), pituitary gland (C751) craniopharyngeal duct (C752), and pineal gland (C753) that were diagnosed in 2004 or later.

Note: These types of cases are not required by TCR. This would be used for reportable by agreement cases.

4. Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).

5. A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility.

Class of Case Definitions

Analytic Cases	
Class 00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE. Cases include: • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, or rehabilitative considerations, etc.
Class 10*	Initial diagnosis AND PART OR ALL of first course treatment or a decision not to treat done at the reporting facility, NOS. **Note:** ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.
Class 11	Initial diagnosis by staff physician AND PART of first course treatment was done at the reporting facility.
Class 12	Initial diagnosis by staff physician AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 13*	Initial diagnosis AND PART of first course treatment was done at the reporting facility.
Class 14*	Initial diagnosis AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 20*	Initial diagnosis elsewhere AND ALL OR PART of first course treatment was done at the reporting facility, NOS.
Class 21*	Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility.
Class 22*	Initial diagnosis elsewhere AND ALL treatment or a decision not to treat was done at the reporting facility.
Non-Analytic Cases Patient appears in person at reporting facility Classes of Case not required by CoC to be abstracted. May be required by Cancer Committee, state or regional registry, or other entity.	
Class 30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, staging workup after initial diagnosis elsewhere).
Class 31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care.

Non-Analytic Cases Patient appears in person at reporting facility Classes of Case not required by CoC to be abstracted. May be required by Cancer Committee, state or regional registry, or other entity.	
	Note: In-transit care is given when a patient is temporarily away from the usual physician or treating facility. If the patient begins first course therapy in one location, then completes first course therapy at the reporting facility, this would not be considered in-transit care and the case would be analytic.
Class 32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE.
Class 33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY. **Note:** TCR required these cases only if the patient has active disease or is receiving cancer directed therapy at the time seen.
Class 34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment done by reporting facility.
Class 35	Case diagnosed before program's Reference Date, AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility.
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
Class 37	Case diagnosed before program's Reference Date, AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
Class 38*	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
Patient Does Not Appear in Person at Reporting Facility	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office.
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices.
Class 42	Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
Class 43*	Pathology or lab specimens only.
Class 49*	Death certificate only. **Note:** Used by central registries **only.**
Unknown Relationship to Reporting Facility	
Class 99	Case not required by CoC to be abstracted; Of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases). **Note**: Used by central registries **only**.

*Indicates C*lass of Case* codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

By using *Class of Case* codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using C*lass of Case* in conjunction with *Type of Reporting Source* (500) which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

Class of Case Examples

Code	Reason
00	Reporting facility admits patient due to dizziness and falling. The patient receives clinical workup which includes CT and MRI of the brain. The results are positive for brain metastasis. The patient is discharged to another hospital for treatment for lung cancer with brain metastasis.
10	Patient is diagnosed with lung cancer at the reporting facility. Due to age and comorbidities the decision was made not to treat.
11	A patient is diagnosed with melanoma in a staff physician's office. He has a wide excision at the reporting facility, and then is treated with interferon at another facility.
12	A diagnosis of prostate cancer is made in a staff physician's office. The patient receives radiation therapy at the reporting facility, and no other treatment is given.
13	A patient is diagnosed with colon cancer at the reporting facility and undergoes a hemicolectomy there. She then receives chemotherapy at an outside clinic.
14	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility. The patient did not receive any other treatment.
20	Patient was diagnosed with primary breast cancer at another facility. The patient then comes to the reporting facility for surgery. It is unknown if she received any other treatment.
21	Patient diagnosed at another facility with breast cancer and received neo-adjuvant chemotherapy. She now presents to the reporting facility for modified radical mastectomy.
22	Patient had a biopsy at another facility and the diagnosis was breast cancer. She underwent a mastectomy at the reporting facility and did not receive any further treatment.
32	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer.
38	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
43	A physician does a skin biopsy in his office and sends the biopsy specimen to a reading pathology/lab. The diagnosis is malignant melanoma. The pathology/lab facility is responsible for reporting the case.

Last Name (NAACCR Item #2230) (FORDS pg. 38)

Description
Identifies the last name of the patient.

Explanation
This data item is used as a patient identifier.

Coding Instructions
1. Enter the last name of the patient in **CAPITAL LETTERS.** Blanks, spaces, hyphens, apostrophes, and punctuation marks **are** allowed.

Examples:
a. Record De Leon with a space as DE LEON

b. Record O'Hara with an apostrophe as O'HARA

c. If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

2. Do not leave the data field blank. If the patient's last name is not known, enter UNKNOWN in this field. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

Note: Document in *Text Remarks - Other Pertinent Information:* Last name unknown.

First Name (NAACCR Item #2240) (FORDS pg. 39)

Description
Identifies the first name of the patient.

Explanation
This data item is used to differentiate between patients with the same last name.

Coding Instructions
1. Enter the first name of the patient in **CAPITAL LETTERS**.

2. Blanks, spaces, hyphens and apostrophes are not allowed. Do not use other punctuation.

3. This field may be updated if the name changes.

4. If the patient's first name is unknown, enter UNKNOWN. Do not leave the field blank.

This should be done only as a last resort. Every resource should be exhausted to obtain this information.

Note: Document in *Text Remarks - Other Pertinent Information:* First name unknown.

Middle Name (NAACCR Item #2250) (FORDS pg. 40)

Description
Identifies the middle name or middle initial of the patient.

Explanation
This data item is used to differentiate between patients with identical first and last names.

Coding Instructions
1. Enter the middle initial if the complete middle name is not provided.

2. Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation.

3. This field may be updated if the name changes.

4. If the patient does not have a middle name or initial, or it is unknown, **leave blank**. Do not code UNK for unknown or NA for not applicable.

Maiden Name (NAACCR Item #2390)

Description
Identifies the female patients who are or have been married.

Explanation
This data item is useful for matching multiple records for the same patient and is useful in identifying Spanish/Hispanic origin.

Coding Instructions
1. Enter the maiden name of female patients who are or have been married if the information is available. Blanks, spaces, hyphens, apostrophes, and punctuation marks **ARE** allowed.

2. If the patient does not have a maiden name, or it is unknown, leave blank.

Alias Name (NAACCR Item #2280)

Description
Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name-Maiden [2390].

Explanation
A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Coding Instructions
1. If the patient does not use an alias leave blank. Do not record the patient's first and last name again.

2. Record the **alias** last name followed by a blank space and then the **alias** first name.

3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.

4. No other special characters are allowed.

Examples:
a. Ralph Williams uses the name Bud Williams. Record Williams Bud in the **NAME-ALIAS** field.

b. Janice Smith uses the name Janice Brown. Record Brown Janice in the **NAME-ALIAS** field.

c. Samuel Clemens uses the name Mark Twain. Record Twain Mark in the **NAME-ALIAS** field.

Street Address (NAACCR Item #2330) (FORDS pg. 41)

Description
Identifies the patient's address (number and street) at the time of diagnosis.

Explanation
Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

Note: ACoS facilities **are** required to provide information for this field regardless of class of case.

Coding Instructions
1. Enter the number and street of the patient's residence at the time the cancer is diagnosed in **60 characters or less.** If the address contains more than 60 characters, omit the least important element, such as the apartment or space number.

2. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type (street, drive, lane, road, etc.).

3. Punctuation marks are limited to periods, slashes, hyphens and pound signs in this field.

4. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.

5. Abbreviate as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service (USPS). These include but are not limited to:

ABBREV.	DEFINITION	ABBREV.	DEFINITION	ABBREV.	DEFINITION
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

Example:
Patient's street address is 1232 Southwest Independence Apartment 400. Record: 1232 SW Independence Apt 400

Patients with an Unknown Address:

6. If the patient's address is not available in the medical record, record **NO ADDRESS** or **UNKNOWN. Do not** leave blank. These cases should be rare and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city **Unknown**, the state as **ZZ,** the zip code should be **99999** and the FIPS as **999**. **Do not record the reporting facility's city, state, zip and FIPS.**

Note: Document in *Text Remarks - Other Pertinent Information:* Patient address is unknown. Be aware that an excessive amount of unknown addresses will result in additional efforts by TCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

7. Log onto https://tools.usps.com/go/ZipLookupAction!input.action for help in completing address information,

Persons with More than One Residence:
These include snowbirds who live in the south for the winter months, sunbirds who live in the north during the summer months. This also includes persons with vacation residences which they occupy for a portion of the year.

8. Code the residence where the patient spends the majority of time (usual residence).

9. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence:
Homeless people and transients are examples of persons with no usual residence.

10. Code the patient's residence at the time of diagnosis as unknown.

Note: Under pertinent information document that patient is homeless. An unknown address is not the same as homeless.

Temporary Residents:
11. Code the place of usual residence rather than the temporary address for:
a. Migrant workers
b. Persons temporarily residing with family during cancer treatment
c. Military personnel on temporary duty assignment
d. Boarding school students below the college level (code the parent's residence)

12. Code the residence where the student is living while attending **college.**

13. Code the address of the institution for **Persons in Institutions**.
a. Persons who are incarcerated
b. Persons who are physically or mentally handicapped or mentally ill who are residents of homes, schools, hospitals, or wards.
c. Residents of nursing and rest homes
d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine):
14. **Armed Forces—**For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

15. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships—**The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules at www.census.gov.

Address at Dx—Supplemental (NAACCR Item #2335) (FORDS pg. 42)

Description
Provides the ability to store additional address information such as the name of a place or facility (a nursing home or name of an apartment complex).

Explanation
A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, or other elements necessary to locate an address on a street file for the purpose of geocoding.

Coding Instructions
1. Do not use this data item to record the number and street address of the patient.

2. Do not update this data item if the patient's address changes.

3. If this address space is not needed, leave blank.

City (NAACCR Item #70) (FORDS pg. 43)

Description
Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

Explanation
Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions
1. Enter the city of residence at the time the cancer is diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address.

2. Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting.

3. If the patient has multiple primaries, the address may be different for subsequent primaries.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

State (NAACCR Item #80) (FORDS pgs. 44-45)

Description
Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

Explanation
It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions
1. Record the appropriate **two-letter abbreviation** for state of residence at the time of diagnosis.

2. If the patient is a resident of Canada, record the appropriate **two-letter abbreviation** for the country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See page 61 for a list of Canadian Provinces/Territories.

3. If the patient is a foreign resident, other than Canada, record either **XX** or **YY** depending on the circumstance. Refer to the table below for specific instructions.

4. If the patient has multiple primaries, the state of residence may be different for subsequent cases.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Code	Definition
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **known.**
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **unknown.**
ZZ	Residence unknown.

Examples:
a. A patient's country of residence is documented as France; record XX in the state field.

b. Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record YY in the state field.

c. The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided; record US in the state field.

d. If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field.

Canadian Provinces/Territories:

Province/Territory	Abbreviation	Province/Territory	Abbreviation
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NF	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS		

State and Territory Abbreviations:
(Refer to the ZIP Code directory for further listings).

State		State		State	
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

Other U.S. Territories	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI

Zip Code (NAACCR Item #100) (FORDS pg. 46)

Description
Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

Explanation
It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions
1. Enter the patient's zip code at time of diagnosis/admission. Enter the nine-digit extended zip code if known. If recording the full nine-digit zip code, **no dash** should be placed between the first five and the last four digits. The five-digit zip code is allowed if this is all the information available. Blanks follow the five-digit code if the four-digit extension is not coded.

2. If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS website: https://tools.usps.com/go/ZipLookupAction!input.action. This website is useful in obtaining missing address information in order to record a complete address.

3. If the patient is a resident of a foreign country at the time of diagnosis, record **88888** for the zip code.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Code	Definition
123456789	The patient's nine-digit U.S. extended postal code. Do not record dashes.
88888	Permanent address in a country other than Canada, United States, or U.S. possessions.
99999	Resident of the United States (including its possessions, etc.) or Canada and the postal code cannot be verified using the *National Zip Code Directory* or the USPS website.
99999	After every effort is made to obtain a valid address the information remains unknown.
M6G2S8	The patient's valid six character Canadian postal code left justified followed by three blanks.

Examples:
a. A patient's country of residence is documented as France; record 88888 in the zip code field.

b. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.

c. A patient's address is not documented in the medical record and remains unknown after researching all your facility's resources; record 99999 in the zip code field.

Fips County Code at Diagnosis (NAACCR Item #90) (FORDS pg. 47)

Description
Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

Explanation
This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions
1. Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available at: www.epa.gov/enviro/html/codes/state.html.

2. Refer to *Appendix C* for the list of Texas FIPS county codes.

3. If the patient has multiple tumors, the FIPS county codes may be different for each tumor.

4. Do not update this data item if the patient's county of residence changes after diagnosis.

5. ACoS facilities following the FORDS' guideline to code the country of residence in this data field for non-U.S. residents, **CD** and **XX** will be accepted by the TCR Edits.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as Unknown in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Code	Description	Definition
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known **AND** a resident outside the state of Texas (must meet all criteria)
999	Unknown county	The county is unknown and not documented in the patient's medical record

Social Security Number (NAACCR Item #2320) (FORDS pg. 37)

Description
Identifies the patient by social security number.

Explanation
This item is used by the TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

Coding Instructions
1. Every effort should be made to obtain the social security number. Research all resources from your facility for this information.

2. Enter the patient's nine-digit social security number in this field.

3. If the social security number is unavailable or unknown, enter all 9's in this field. Document in *Text Remarks-Other Pertinent Information* that the social security information is unavailable.

4. A patient's Medicare number may not be identical to the person's social security number.

5. Do not put dashes or slashes in this field.

Note: Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**

The following are not allowed:
- First 3 digits= 000 or 666
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit= 8 or 9 (except for 9999999999)

Date of Birth (NAACCR Item #240) (FORDS pg. 56; SEER pgs. 29)

Description
Identifies the patient's century, year, month, and day of birth.

Explanation
This item is used by the TCR to match records, and to calculate age at diagnosis.

Coding Instructions
1. Punctuation marks (slashes, dashes, etc.) are not allowed.

2. The patient's date of birth **must be entered.** Cases cannot be processed without the date of birth.

3. Date format is:
a. YYYYMMDD - when the complete date is known and valid

Example: The patient's date of birth is June 28, 1983. Code the date of birth as 19830628.

b. YYYYMM - when the year and month are known and valid, and the day is unknown.

Example: The patient was born in November of 1981, but the day is unknown. Code 198111.

c. YYYY when the year is known and valid but the month and day are unknown.

Example: The record indicates the patient was born in 1978 but no month or day is given. Code 1978.

Note: If the complete date of birth is not available, documentation must be provided in *Other Pertinent Information.* For example: Medical records indicate only month and year of date of birth.

4. If only the age of the patient is known, calculate the year of birth from age and year of diagnosis and leave the day and month of birth unknown.

Example: A 50 year old patient diagnosed in 2010 is calculated to have been born in 1960.

5. The year of birth *must* be recorded. TCR will not accept unknown year of birth. Every effort must be made to obtain this information as it is critical for analysis.

Code	Definition
YYYYMMDD	The date of birth is the year, month and day the patient was born. The first four digits are the year, the third and fourth digits are the month, the fifth and sixth digits are the month, and the seventh and eighth digits are the day.

Place of Birth (NAACCR Item #250) (FORDS pg. 55; SEER pg. 28)

Description
Identifies the patient's place of birth.

Explanation
Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions
1. Record the patient's place of birth (if available) using the *SEER Geo-codes* in *Appendix G*. If the place of birth is unknown, code to 999. If a patient has multiple tumors, all records should contain the same code.

2. Use the most specific code.

Race 1 (NAACCR Item #160) (FORDS pg. 59; SEER pgs. 33-37)

Description
Identifies the primary race of the person.

Explanation
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions
1. Record the two-digit code to identify the primary race(s) of the patient in fields race 1, race 2, race 3, race 4, and race 5. The five race fields allow for coding of multiple races consistent with the Census 2000.

2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records should have the same race code.

3. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2001.

4. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.

5. If a person's race is a combination of Hawaiian and any other race(s), code race 1 as 07, Hawaiian, and code the other race(s) in race 2, race 3, race 4, and race 5 as appropriate.

6. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Japanese female."

7. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in race 1 and 88 in race 2 - race 5.

8. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South or Latin America.

9. Death certificate information may be used to supplement ante mortem race information only when race is unknown in the patient record or when the death certificate information is more specific.

10. In using the patient name to determine race:
a. Do not code race from name alone, especially for females with no maiden name given.

b. A Spanish name alone may not be used to determine the race code. A statement about

race or place of birth must be documented.

11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code non-white first.

12. If only one race is reported for a person, race 2-race 5 must be coded to 88.

13. If race 1 is coded to 99, unknown, race 2-race 5 must also be coded 99, unknown.

14. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.

15. Document the specified race code in the *Text Remarks - Other Pertinent Information* field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Codes for Race Codes 1 - 5

Code	Race	Code	Race
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown

- The **White** category usually includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians including those from Europe and the Middle East.
- The **Black** category includes the designation African-American.

Examples:

Race Code	Explanation
01	-A patient was born in Mexico of Mexican parentage. -A patient stated to be German-Irish. -A person from Iran or Saudi Arabia. -An immigrant from Sweden.

Race Code	Explanation
02	A black female patient. **Note:** A specific race code (other than blank or 99) must not occur more than once. For example, do not code Black in race 1 for one parent and Black in race 2 for the other parent.
04	A patient is of Chinese and Korean ancestry. Code 04, Chinese in Race 1. Code 08, Korean, in Race 2.
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in Race 1 and 01 White in Race 2.
07	A patient's race is a combination of Hawaiian and any other race(s). Code 07, Hawaiian, in Race 1 and Race 2–Race 5 as appropriate.
11	A patient is stated to be Asian. The place of birth is Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race.

Race 2, Race 3, Race 4, Race 5 (NAACCR Items #161, 162, 163, 164) (FORDS pgs. 61-64; SEER pgs. 33-37)

Description
Identifies the patient's additional races. Race is defined by specific physical, heredity, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Explanation
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons.

Coding Instructions
1. Record the two-digit code to identify a multi-racial patient.

2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All primaries for the same patient should have the same race code.

3. All resources in the facility must be used to determine the race of the patient.

4. If more than the *Race 1* code is entered, and if any race is **99**, then all race codes (*Race 1, 2, 3, 4* and *5*) must be **99**. If more than the *Race 1* code is entered, and if any race codes (for *Race 2, 3, 4* and *5*) are **88** (no further race documented), then all **subsequent** race codes must also be **88**.

5. If a person's race is a combination of Hawaiian and any other race(s), code *Race 1* as 07 Hawaiian and code the other race(s) in *Race 2, Race 3, Race 4,* and *Race 5* as appropriate.

6. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Hispanic female."

7. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in *Race 1* and 88 in *Race 2–Race 5*.

8. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South, or Latin America.

9. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

10. In using the patient name to determine race:

a. Do not code race from name alone, especially for females with no maiden name given.

b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.

11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code the non-white first.

12. If only one race is reported for a person, *Race 2–Race 5* must be coded to 88.

13. If race 1 is coded to unknown 99, *Race 2–Race 5* must also be coded unknown 99.

14. A unique race code (other than 88 or 99) can be coded only once in *Race 1* through *Race 5*.

15. Document the specified race code in the *Text Remarks - Other Pertinent Information* text field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Spanish/Hispanic Origin (NAACCR Item #190) (FORDS pg. 65; SEER pg. 40)

Description
Identifies persons of Spanish or Hispanic origin. If a patient has multiple tumors, all records should have the same code.

Explanation
This is used to identify whether or not the person should be classified as *Hispanic* for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White) category of *race.*

Coding Instructions

1. The information is coded from the medical record or is based on Spanish/Hispanic names.

2. Review all sources available to determine the correct code, including stated Hispanic ethnicity. Origin on the death certificate, birthplace and information about life history and language spoken should be considered.

3. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.

4. Portuguese, Brazilians and Filipinos are not presumed to be Spanish or non-Spanish.
a. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.
b. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.

Note: Refer to the list of Spanish/Hispanic surnames on the TCR website at: http://www.dshs.state.tx.us/tcr/publications/2008crhb/web/2006HB-AppxM.pdf.

Code	Description
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (includes European; excludes Dominican Republic)
6	Spanish, NOS, Hispanic, NOS; Latino, NOS. There is evidence, other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5.
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Note: Use **code 0** if patient has a Spanish/Hispanic name and there is reason to believe he/she is **not** Hispanic, for example, patient is Filipino or patient is a woman with a Hispanic married name but she is known to be non-Hispanic.

5. Use codes 1–5 if specific ethnicity is known.

6. Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.

7. Use code 7 if race in the medical record is classified as White and he/she has a Spanish/Hispanic last name. Ordinarily used at the central registry level.

8. Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

Examples:
a. Patient's last name is Gonzales and the medical record states the patient was born in Mexico; code to 1.

b. Patient's medical record states race as Hispanic, without mention of whether his/her origin was Mexico, Puerto Rico, Cuba, etc.; code to 6.

c. Patient's medical record states patient is White/Caucasian and the last name is Gonzales; code to 7.

Sex (NAACCR Item #220) (FORDS pg. 66; SEER pg. 44)

Description
Identifies the gender of the patient at the time of diagnosis.

Explanation
This data item is used to compare cancer rates and outcomes by site.

Coding Instructions
1. Record the patient's gender as indicated in the medical record.

2. The code must be gender-specific to the primary site.

Example: The patient must be coded as male for a prostate cancer, or female for ovarian primary.

3. If the patient has multiple tumors the sex must be the same for all records.

Code	Definition
1	Male
2	Female
3	Other (Hermaphrodite) (Intersexed)
4	Trans-sexual
9	Not Stated/Unknown

Note: Trans-sexual is defined as surgically altered gender.

Note: Transgendered is defined as a person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth. Assign code 4 for Transgendered.

Text Usual Industry (NAACCR Item #320)

Description
Text area for information about the patient's usual industry, also known as usual kind of business/industry

Explanation
Used to identify work-related health hazards; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Definition
Type of business or industry where the patient worked in his or her usual occupation. Examples include manufacturing of tires, dry cleaning services, training of dogs, hospital.

Instructions
1. Document the patient's usual (longest held) industry to the extent that the information is available in the medical record.

2. Be descriptive and specific.

Examples
Inadequate: "Automobile industry"
Adequate: "Automobile manufacturing"

Inadequate: "Mine"
Adequate: "Copper mine"

Inadequate: "Retail"
Adequate: "Retail bookstore"

3. When recording government agencies record the level (federal, state, county, municipal) and the division.

Example
Inadequate: "Census"
Adequate: "U.S. Census Bureau"

4. Be complete. If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.

Example
Inadequate: "ABC, Inc."
Adequate: "ABC, Inc., Kyle, TX"

5. If the patient's usual industry is unknown, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation (NAACCR Item #310)

Description
Text area for information about the patient's usual occupation, also known as usual type of job or

work.

Explanation
Used to identify work-related health hazards; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Definition
Type of job the patient was engaged in for the longest time. It is not necessarily the highest paid job or the job considered the most prestigious, but the one that accounted for the greatest number of working years. Examples include police officer, bank teller, or nurse.

Exception
If a patient has been a homemaker for most of her adult life, but has ever worked outside the home, report the occupation held outside the home.

Instructions
1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the medical record. Make sure the recorded usual occupation matches the recorded industry.

2. Be descriptive, specific and complete: Record the word or words which most clearly describe the kind of work or type of duties performed by the patient.

Examples
Inadequate: "Teacher"
Adequate: "Preschool teacher," "high school teacher"

Inadequate: "Laborer"
Adequate: "Residential bricklayer"

Inadequate: "worked in a warehouse," "worked in a shipping department"
Adequate: "warehouse forklift operator"

Inadequate: "Engineer"
Adequate: "Chemical engineer," "Railroad engineer"

Inadequate: "Self-employed"
Adequate: "Self-employed auto mechanic"

3. If the patient's usual occupation is not known, document "Unknown" in the text field. This should be used only as a last resort.

Commonly confused occupations
Contractor vs. skilled worker

a. A contractor mainly obtains contracts and supervises work
b. A "skilled worker" works with his or her own tools as a carpenter, plasterer, plumber or electrician.

Machine operator vs. machinist vs. mechanic
a. A "machine operator" operates machines.
b. A "machinist" sets up and operates machines.
c. A "mechanic" repairs, installs, and adjusts machines.

Text Remarks - Other Pertinent Information (NAACCR Item #2680)

Description
Includes text area for information that is coded on the patient's disease and adequate or appropriate space is not provided for supporting text. Overflow or problematic coding issues can be documented in this text field.

Explanation
Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation should include additional staging information, additional treatment documentation, documentation of race and sex, history of the disease, comments regarding lack of information in the medical record and cause of death. The name of the following (Follow Up) physicians should also be noted here. See the Text Documentation Section for detailed instructions.

Physician Follow Up (NAACCR Item #2470)

Description
Identifies the physician currently responsible for the patient's medical care. The TCR requires the physician's state license number.

Explanation
The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

Coding Instructions
1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following website: www.docboard.org/tx/df/txsearch.htm

2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.

3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999 and document in *Text Remarks - Other Pertinent Information* that the follow up physician is unknown.

Note: Beginning in 2011 CoC will no longer require data item 2470, *Following Physician.* TCR will continue to require this data item.

Sequence Number (NAACCR Item #560) (FORDS pgs. 34 - 35)

Description
Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of when or where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable malignant neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, an ACoS registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facility's reference date.

Explanation
This data item is used to distinguish among cases having the same registry numbers, to select patients with only one primary tumor for certain follow-up studies and to analyze factors involved in the development of multiple tumors.

Coding Instructions
1. Codes 00–59 and 99 indicate reportable cases of malignant or in situ behavior.

2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent reportable primary, change the code for the first primary from 00 to 01, and number subsequent primaries sequentially.

3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
a. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries
b. If there is no difference in prognosis, the sequence numbers may be assigned in any order

4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility should be sequenced according to this guideline. This includes benign and borderline CNS neoplasms.

5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63…).

6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.

7. The *Sequence Number* refers to the number of malignant or non-malignant primaries **in the**

patient's lifetime.

Malignant Neoplasms		
One Primary	**More Than One Primary**	**Sequence Unknown**
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Non-Malignant Neoplasms		
One Primary	**More Than One Primary**	**Sequence Unknown**
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Note: Squamous and/or basal cell carcinoma of the skin (except genital sites) **are no longer** considered when assigning the appropriate sequence number.

Examples:
a. A person is diagnosed with one malignant primary. Code the sequence number to 00.

b. A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2012. Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.

c. A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs in June 2012. Since the lung is a metastatic site and not a second primary, it would not be abstracted. Code the sequence number of the breast cancer to 00.

d. A person was diagnosed with signet ring cell carcinoma of the bladder in 2004. In 2012, this person developed a benign meningioma in the temporal area of the brain. Code the bladder to sequence number 00, and code the brain to sequence number 60.

e. A person was diagnosed with carcinoma of the stomach in 2003, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2005, and non-Hodgkin's lymphoma in 2012. Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted or reported. Code the sequence number of the lymphoma to 02.

f. A person was diagnosed with a benign meningioma in June 2007. MRI at your facility in 2012 shows no change. *Code the sequence number to 60 for the benign meningioma.*

Other Primary Tumors (Site, Morphology, Date) NAACCR Item #2220)

Description
State-specific data field to capture information on other reportable tumors.

Explanation
Records tumor specific information on other reportable tumors in the patient's lifetime.

Coding Instructions
1. Record the site, morphology, and date of diagnosis of other primaries. **Do not** include metastatic lesions or the primary currently being reported in this field. **Do not** leave this area blank due to lack of specific information. Record the information you have available.

Examples:
a. The patient had a history of duct cell carcinoma of the left breast in 2005 and is admitted in 2012 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and document duct cell carcinoma of left breast in 2005 in this field.

b. The patient has a history of prostate cancer, no date or specific morphology is given. Patient is admitted in 2012 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.

2. This field may be left blank if the sequence number is 00 for a malignant neoplasm or 60 for a non-malignant neoplasm.

Primary Payer at Diagnosis (NAACCR Item #630) (FORDS pgs. 67-68)

Description
Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Explanation
This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions
1. Record the type of insurance reported on the patient's admission page.

2. If more than one payer or insurance carrier is listed on the patient's admission page, record the first.

3. If the patient's payer or insurance carrier changes, do not change the initially recorded code.

4. Consult with your facility's billing department if the primary payer information is unclear.

Code	***Label***	***Definition***
01	*Not insured*	*Patient has no insurance and is declared a charity write-off*

Code	***Label***	***Definition***
02	*Not insured, self-pay*	*Patient has no insurance and is declared responsible for charges*
10	*Insurance, NOS*	*Type of insurance unknown or other than types listed in codes 20, 21, 31, 35, 60-68*
20	*Private Insurance: Managed Care, HMO, or PPO*	*An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.*
21	*Private Insurance: Fee-for-Service*	*An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.*
31	*Medicaid*	*State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.*
35	*Medicaid-Administered through a Managed Care plan*	*Patient is enrolled in Medicaid through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.*
60	*Medicare without supplement, Medicare, NOS*	*Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Not described in codes 61, 62, or 63.*
61	*Medicare with supplement, NOS*	*Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.*
62	*Medicare-Administered through a Managed Care plan*	*Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.*
63	*Medicare with private supplement*	*Patient has Medicare and private insurance to pay costs not covered by Medicare.*
64	*Medicare with Medicaid eligibility*	*Federal government Medicare insurance with State Medicaid administered supplement.*
65	*TRICARE*	*Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents.* *Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)*
66	*Military*	*Military personnel or their dependents treated at a military facility*
67	*Veterans Affairs*	*Veterans treated in Veterans Affairs facilities*

Code	*Label*	*Definition*
68	*Indian/Public Health Services*	*Patient who receives care at an Indian Health Services facility or at another facility and medical costs are reimbursed by the Indian Health Service Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service*
99	*Insurance status unknown*	*It is unknown from the patient's medical record whether or not the patient is insured.*

Examples:
a. An indigent patient is admitted with no insurance coverage. Code the *Primary Payer at Diagnosis* as 01.

b. A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO. Code the *Primary Payer at Diagnosis* as 20.

c. A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO. Code the *Primary Payer at Diagnosis* as 62.

d. Patient comes to your facility originally diagnosed with prostate cancer in 2000. Now he has bone metastasis. Code the *Primary Payer at Diagnosis* as 99 because the information from the facility where originally diagnosed is not available.

Tobacco Use Cigarettes (Non-NAACCR Standard Data Item 9965) (Source CDC/NPCR-CER)

Description
Records the patient's past or current cigarette smoking. This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview

Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1**.** If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Code	Description
0	Never used
1	Current user (as of Date of diagnosis)
2	Former user, quit within one year of the date of diagnosis

3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Tobacco Use Other Smoke (Non-NAACCR Standard Data Item 9966) (Source CDC/NPCR-CER)

Description
Records the patient's past or current use of smoking tobacco products other than cigarettes (pipes, cigars, and kreteks). This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Code	Description
0	Never used
1	Current user (as of Date of Diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Tobacco Use Smokeless (Non-NAACCR Standard Data Item 9967) (Source CDC/NPCR-CER)

Description
Records the patient's past or current use of smokeless tobacco products (chewing tobacco, snuff, etc.)

This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Code	Description
0	Never used
1	Current user (as of Date of Diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Tobacco Use NOS (Non-NAACCR Standard Data Item 9968) (Source CDC/NPCR-CER)

Description
Records the patient's past or current use of tobacco when tobacco use is indicated but type is not specified. This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions

1**.** If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Code	Description
0	Never used
1	Current user (as of Date of Diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

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